DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

Region IX
Division of Medicaid & Children's Health Operations
90 Seventh Street, Suite 5-300 (5W)
San Francisco, CA 94103-6706

SEP 1 1 2009

Toby Douglas
Chief Deputy Director of Health Care Programs
California Department of Health Care Services
1501 Capital Avenue, MS 0000
P. O. Box 997413
Sacramento, CA 99859-7413

Dear Mr. Douglas:

Enclosed is our Financial Management Review (Control Number 09-FS-2008-CA-02-F) entitled "Interim Reconciliation Process for CPE-Funded Inpatient Hospital Reimbursement Under the California Medi-Cal Hospital/Uninsured 1115 Demonstration Waiver". This final report incorporates the State's response dated August 19, 2009.

Thank you for your staff's support and their cooperation in completing this review.

Sincerely,

Gloria Nagle

Gloria Nagle, Ph.D., MPA
Associate Regional Administrator
Division of Medicaid and Children's Health Operations

Financial Management Review

INTERIM RECONCILIATION PROCESS FOR CPE-FUNDED INPATIENT HOSPITAL REIMBURSEMENT UNDER THE CALIFORNIA MEDI-CAL HOSPITAL/UNINSURED 1115 DEMONSTRATION WAIVER

STATE OF CALIFORNIA
DEPARTMENT OF HEALTH CARE SERVICES

FOR THE STATE FISCAL YEAR 2005-06

Control Number

09-FS-2008-CA-02-F

September 10, 2009

DIVISION OF MEDICAID AND CHILDREN'S HEALTH OPERATIONS
CENTERS FOR MEDICARE & MEDICAID SERVICES
SAN FRANCISCO REGIONAL OFFICE

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I. EXECUTIVE SUMMARY

The Centers for Medicare and Medicaid Services (CMS) San Francisco Regional Office (RO) reviewed the State of California's interim reconciliation process for compliance with the certified public expenditure (CPE) protocol approved in the Special Terms and Conditions (STCs) of the California Medi-Cal Hospital/Uninsured 1115 Demonstration Waiver ("Waiver") and California State Plan.

The original scope of our review was to look at the interim reconciliations for all CPE-funded activities under the waiver including Medi-Cal inpatient hospital services, DSH, and SNCP hospital payments; however, we found that the DSH and SNCP reconciliations were not completed as required by the waiver Special Terms and Conditions and the State Plan. The State stated that was because they were awaiting CMS approval of a related SPA and the non-hospital based clinic cost funding methodology; the SPA was approved December 2007 and the methodology in March 2008. Accordingly, we will be following up to ensure that these interim reconciliations are completed as specified by the State. Therefore, this review only examined the interim reconciliations of Medi-Cal inpatient hospital reimbursements for the 22 designated hospitals[1] under the State Plan.

Overall, the State complied with the CPE protocol in the approved State Plan and Waiver. However, in calculating the interim reconciliation, the State deviated from the Waiver and State Plan by failing to include all revenues as offsets to program costs before the State calculated the total cost eligible for federal match. Instead, the State included certain revenues as additional offsets to only the federal share after the initial determination of total costs eligible for federal match. The result is an under-reimbursement of FFP to California.

By letter dated August 19, 2009, DHCS responded to the report that it concurred with the recommendation. DHCS has revised the Medi-Cal reconciliation computation accordingly. The State's final reconciliation for Fiscal Year 2005/06 will reflect the revised format.

II. INTRODUCTION/BACKGROUND

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[1] The 22 designated hospitals are sometimes referred to as 23 designated hospitals. UCLA and UCLA-Santa Monica are counted as one facility in the Waiver. The 22 designated hospitals include: State Government Operated University of California Hospitals – UC Davis Medical Center, UC Irvine Medical Center, UC San Diego Medical Center, UC San Francisco Medical Center, and UC Los Angeles Medical Center. The other seventeen non-State government-operated hospitals are: Los Angeles County owned, Harbor/UCLA Medical Center, Harbor/Martin Luther King Medical Center, Olive View Medical Center, Rancho Los Amigos National Rehabilitation Center, University of Southern California Medical Center, Alameda County Medical Center, Arrowhead Regional Medical Center, Contra Costa Regional Medical Center, Kern Medical Center, Natividad Medical Center, Riverside County Regional Medical Center, San Francisco General Hospital, San Joaquin General Hospital, San Mateo County General Hospital, Santa Clara Valley Medical Center, Tuolumne General Hospital, and Ventura County Medical Center.

On August 31, 2005, CMS approved a new Section 1115 Demonstration Waiver for California, entitled the "Medi-Cal Hospital/Uninsured Care Demonstration Waiver" (Waiver 11-W-00193/9). This Waiver, in conjunction with the California Medicaid State Plan (Section Attachment 4.19A, page 46, "Reimbursement to Specified Government-Operated Hospitals for Inpatient Hospital Services," and page 18, "Increase in Medicaid Payment Amounts for California Disproportionate Share Hospitals"), governs the reimbursement for Medicaid fee-for-service (FFS) inpatient hospital services and expenditures under the DSH Program. The Waiver also created a "Safety Net Care Pool" to provide funding for the care of uninsured individuals. As agreed to in the Waiver, the 22 designated governmental hospitals are reimbursed for Medi-Cal FFS inpatient hospital services, DSH, and SNCP expenditures on the basis of CPEs.

In California, the Department of Health Care Services (DHCS) is responsible for administering the State's Medicaid Program (called "Medi-Cal" in California). During each fiscal year, DHCS makes interim payments to the 22 governmental hospitals based on each hospital's CPEs for Medi-Cal FFS, DSH, and the SNCP, in accordance with a CPE protocol approved by CMS and incorporated into the STCs of the Waiver[2] and the State Plan. These interim payments are later reconciled through a two-step process to actual costs. The first step in this two-step process is an interim reconciliation of interim payments to the cost, as captured on the Medi-Cal "as filed" cost report.

III. PURPOSE AND SCOPE

The purpose of the review is to: (1) determine if the interim reconciliation calculation for Medi-Cal hospital inpatient, DSH and SNCP payments are in compliance with the STCs of the Waiver and CPE protocol, and if the calculations can be supported by the information from the Medi-Cal "as filed" cost report; and (2) determine if any overpayments resulting from the reconciliation are returned to the Federal government.

Our review was conducted June 23 through June 26, 2008, at the State's offices in Sacramento, California.

Review Process

The review included compiling information from DHCS staff on the procedures they used to calculate the interim reconciliation. We also reviewed the completed "Workbook"[3] and related source documents, submitted by each hospital to calculate the interim payment. Specifically, we:

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[2] On October 5, 2007, the Waiver was amended to incorporate the approved CPE protocol and the STCs were renumbered. However, all references to STCs in this report refer to the Waiver as originally approved.

[3] The CPE Protocols are also referred to as Paragraph 14 of the Special Terms and Conditions. The designated hospitals refer to the CPE protocols as Paragraph 14 or the "Workbook."

1. Traced the information in the Workbook to the "as filed" 2005 Medi-Cal Cost Report, Worksheets B, C, and D;

2. Reviewed the Medicaid Management Information System (MMIS) download containing the details of interim payments made to each provider during the service dates July 1, 2005 through June 30, 2006;

3. Verified that the State's calculation of both the routine and ancillary costs is adjusted to the MMIS reported Medicaid days and charges;

4. Verified that the State's calculation of provider total Medicaid costs incorporates any audit recommendations from the 2005 Audits and Investigations (A & I) audit adjustments report;

5. Verified that the State's calculation of total cost is adjusted for revenues and other costs, i.e. share of cost (SOC), collected on behalf of patients and;

6. Verified that the State returned the Federal share of overpayments back to the Federal government.

IV. FINDINGS

The State deviated from the State Plan and Waiver by failing to include all revenues as offsets to program costs before the State calculated the total cost eligible for federal match.

In determining cost-reimbursement, the State Plan and Waiver authorize Federal Financial Participation (FFP) for allowable costs less any revenues. The California State Plan, Attachment 4.19-A (page 46), paragraph B. titled – General Reimbursement Requirements, allows that:

> "Eligible hospitals may receive payments for specified inpatient hospital services that are paid independent of the cost-based payments specified in subparagraph B.1. Services to be paid pursuant to this subparagraph B.2 will be determined by the State. Such payments will be appropriately offset against the hospital costs pursuant to subparagraph C.1.d, subparagraph D.3 and E.4."

The State did not include all revenues as offsets to program costs before the State calculated the total cost eligible for federal match. Instead, the State: 1) calculated an initial amount representing total net costs; 2) applied the FMAP rate; then 3) further reduced the federal share to adjust for revenues received for administrative days and other revenues received on behalf of the patient, such as copayments. The scenario in which the FMAP split is done first, and then the revenue adjustments are applied to just

the Federal share, reduces the effective FMAP rate below California's required FMAP rate of 50% for FFY 2005-2006.

The remaining interim reconciliation calculation and the supporting documentation (for the Medi-Cal inpatient payments) comply with the CPE Protocol as approved in the Waiver and California State Plan. The workbooks used to calculate the interim reconciliation comply with the instructions on page 5 of the CPE Protocol.

V. OBSERVATIONS

The State Plan under Title XIX of the Act, Attachment 4.19-A (page 49), paragraph D-1 and the CPE protocol call for:

> "Each eligible hospital interim Medicaid payments with respect to services rendered in a fiscal year will be reconciled to its Medi-Cal 2552-96 cost report for that same fiscal year."

At the time of this review, the State had completed the interim reconciliation of CPE funded Medi-Cal inpatient payments, but the interim reconciliation for both the Disproportionate Share Hospital (DSH) payments and the Safety Net Care Pool (SNCP) payments had not been completed.

The State explained that the DSH and SNCP interim reconciliations were delayed because DHCS could not determine SNCP funds needed to meet baselines.

Based on State regulations[4], the State is required to: a.) Establish a baseline for each designated public provider and, b.) Verify that each provider meets the baseline requirement. This is accomplished when the SNCP Division establishes a calculated amount equal to the baseline amount for each designated provider, and then compares each baseline amount against the total current year payments made to the provider.

The sum of the current year payments made to the provider includes four components: a.) Medi-Cal fee-for-service (FFS) payments, b.) DSH payments made to the designated provider, c.) Payments made under the physician SPA for inpatient hospital services, and, d.) Payments for non-hospital based clinic services.

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[4] *Section 14166.6* of the California's Welfare and Institutions Code (CWIC) requires DHCS to establish a baseline funding amount for each designated hospital. The baseline amount consists of five types of payments each hospital received during the State fiscal year (SFY 2004-2005). The five components include: 1.) Per Diem payments, 2.) Administrative day payments, 3.) DSH payments, 4.) Emergency Services and Supplemental fund payments, and 5.) Medical Education payments.

Section 14166.4 and 14166.8 of the CWIC further specifies that payments made under the 1.) Physician SPA for inpatient hospital services, and 2.) Payments for non-hospital based clinic services must be applied in determining whether the hospital baseline have been met.

California law established the priority for claiming SNCP funds which pass through the State's Health Care Support fund. The first draw against these funds goes to meet hospital baselines. If Medi-Cal and DSH payments to hospitals during a project year do not meet the baseline or adjusted baseline, funding is drawn from the SNCP using the hospital CPE expenditures to make up the difference. After baselines have been met, the balance of the SNCP, can then be claimed based on the hospital CPE expenditures, and is later distributed according to California statue.

The State stated that the CMS delay in approving both the physician cost State Plan Amendment (SPA 05-023), and the non-hospital based clinic cost funding methodology caused delays for DHCS as the State could not determine the SNCP funds needed to establish hospital baselines.

The State submitted CA SPA 05-023 in September 2005, and CMS approved the SPA in December 2007. The non-hospital based clinic cost funding methodology was approved in March 2008.

The DSH and SNCP interim reconciliations, according to the State are expected to be completed by the fall of 2008 and CMS will follow-up to ensure this timeframe is met.

VI. RECOMMENDATIONS

We recommend that California change its interim reconciliation calculation to ensure that the total cost is net of all revenues before determining the amount eligible for FFP. The full cost is the cost available for FFP, once any revenues have been subtracted.

VII. STATE'S COMMENTS

By letter dated August 19, 2009, DHCS responded to the report that it concurred with the recommendation. DHCS has revised the Medi-Cal reconciliation computation accordingly. The final reconciliation for Fiscal Year 2005/06 will reflect the revised format.

There has been no Medi-Cal interim reconciliation performed for any subsequent years of the Waiver.

A copy of the State's response is attached to the report.

DHCS
SANDRA SHEWRY
Director

State of California—Health and Human Services Agency
Department of Health Care Services

ARNOLD SCHWARZENEGGER
Governor

AUG 19 2009

Ms. Gloria Nagle
Associate Regional Administrator
Division of Medicaid and Children's Health Operations
Centers for Medicare & Medicaid Services
90 Seventh Street, Suite 5-300 (5W)
San Francisco, CA 94103-6706

Dear Ms. Nagle:

The California Department of Health Care Services (DHCS) has prepared its response to the draft report entitled "Interim Reconciliation Process for CPE-Funded Inpatient Hospital Reimbursement Under the California Medi-Cal Hospital/Uninsured 1115 Demonstration Waiver" (Control Number 09-FS-2008-CA-02-D). The DHCS appreciates the work performed by the Centers for Medicare & Medicaid Services and the opportunity to respond to the draft report.

Please contact Ms. Jalynne Callori, Assistant Chief, Safety Net Financing Division, at (916) 552-9215 if you have any questions.

Sincerely,

Toby Douglas
Chief Deputy Director
Health Care Programs

Enclosure

cc: Ms. Jalynne Callori
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Sacramento, CA 95899-7419

Response to the Centers for Medicare & Medicaid Services'
Draft Report Entitled

"Interim Reconciliation Process for CPE-Funded Inpatient Hospital Reimbursement Under the California Medi-Cal Hospital/Uninsured 1115 Demonstration Waiver"
Control Number 09-FS-2008-CA-02-D

Recommendation: We recommend that California change its interim reconciliation calculation to ensure that the total cost is net of all revenues before determining the amount eligible for FFP. The full cost is the cost available for FFP, once any revenues have been subtracted.

Response: We concur with the recommendation and have revised the Medi-Cal reconciliation computation accordingly. The final reconciliation for Fiscal Year 2005/06 will reflect the revised format.

There has been no Medi-Cal interim reconciliation performed for any subsequent years of the Waiver.